		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027540

Facility Name: Manorcare at Oak Lawn/95th

Address: 6300 W. 95th St. (Number) Oak Lawn (City) 60453 (Zip Code)

County: Cook

Telephone Number: (708)599-8800 **Fax #** (708)599-8820

IDPA ID Number: 520886946015

Date of Initial License for Current Owners: 11/01/81

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Gary Geise **Telephone Number:** (419) 252-5731

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/03 to 05/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Barry A. Lazarus
(Title) Vice President, Reimbursement

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Manorcare at Oak Lawn/95th # 0027540 Report Period Beginning: 06/01/03 Ending: 05/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	195	Skilled (SNF)	195	71,370	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	195	TOTALS	195	71,370	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,749	11,342	30,325	54,416	8
9	SNF/PED					9
10	ICF	3,247	2,356	862	6,465	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,996	13,698	31,187	60,881	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.30%

D. How many bed-hold days during this year were paid by Public Aid?
75 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/81

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 174 and days of care provided 16,860

Medicare Intermediary CareFirst of Maryland, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/04 Fiscal Year: 05/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Manorcare at Oak Lawn/95th # 0027540 Report Period Beginning: 06/01/03 Ending: 05/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	364,943	34,889	6,580	406,412	3,625	410,037		410,037			1
2	Food Purchase		249,961		249,961		249,961	(302)	249,659			2
3	Housekeeping	199,708	26,100	1,817	227,625		227,625		227,625			3
4	Laundry	52,305	22,769	874	75,948		75,948		75,948			4
5	Heat and Other Utilities			207,920	207,920	13,209	221,129		221,129			5
6	Maintenance	75,119	13,662	76,672	165,453		165,453		165,453			6
7	Other (specify):* Medical Waste			2,302	2,302		2,302		2,302			7
8	**TOTAL General Services**	692,075	347,381	296,165	1,335,621	16,834	1,352,455	(302)	1,352,153			8
	B. Health Care and Programs											
9	Medical Director			28,500	28,500		28,500		28,500			9
10	Nursing and Medical Records	3,758,751	337,733	31,972	4,128,456	89,793	4,218,249		4,218,249			10
10a	Therapy	803,633	7,462	149,481	960,576	150	960,726		960,726			10a
11	Activities	128,128	3,704	3,209	135,041		135,041		135,041			11
12	Social Services	93,461	1,586		95,047		95,047		95,047			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,783,973	350,485	213,162	5,347,620	89,943	5,437,563		5,437,563			16
	C. General Administration											
17	Administrative	118,667		815,094	933,761	(410,553)	523,208		523,208			17
18	Directors Fees											18
19	Professional Services			53,007	53,007	(14,508)	38,499	(38,499)				19
20	Dues, Fees, Subscriptions & Promotions			80,408	80,408		80,408	(37,107)	43,301			20
21	Clerical & General Office Expenses	452,266	45,658	214,132	712,056	2,339	714,395	(118,488)	595,907			21
22	Employee Benefits & Payroll Taxes			992,315	992,315	87,899	1,080,214		1,080,214			22
23	Inservice Training & Education			3,971	3,971		3,971		3,971			23
24	Travel and Seminar			5,495	5,495		5,495		5,495			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			232,139	232,139		232,139		232,139			26
27	Other (specify):* Purchase Service Admin.											27
28	**TOTAL General Administration**	570,933	45,658	2,396,561	3,013,152	(334,823)	2,678,329	(194,094)	2,484,235			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,046,981	743,524	2,905,888	9,696,393	(228,046)	9,468,347	(194,396)	9,273,951			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Manorcare at Oak Lawn/95th #0027540 Report Period Beginning: 06/01/03 Ending: 05/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			536,788	536,788	47,631	584,419		584,419			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,925	17,925	180,265	198,190		198,190			32
33	Real Estate Taxes			460,742	460,742		460,742		460,742			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			44,509	44,509		44,509		44,509			35
36	Other (specify):* G/L Assets			1,646	1,646		1,646		1,646			36
37	**TOTAL Ownership**			1,061,610	1,061,610	227,896	1,289,506		1,289,506			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		615,245		615,245	150	615,395		615,395			39
40	Barber and Beauty Shops			11,626	11,626		11,626		11,626			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			107,056	107,056		107,056		107,056			42
43	Other (specify):* IV Therapy, Lab, & X-ray		295,185	183,198	478,383		478,383		478,383			43
44	**TOTAL Special Cost Centers**		910,430	301,880	1,212,310	150	1,212,460		1,212,460			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,046,981	1,653,954	4,269,378	11,970,313		11,970,313	(194,396)	11,775,917			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Manorcare at Oak Lawn/95th # 0027540 Report Period Beginning: 06/01/03 Ending: 05/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$	10	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(302)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,679)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds		21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(562)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		27		16
17	Non-Care Related Fees				17
18	Fines and Penalties		21		18
19	Entertainment				19
20	Contributions		21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(38,499)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(111,498)	21		24
25	Fund Raising, Advertising and Promotional	(37,107)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Vending & Misc. Income	(749)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (194,396)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (194,396)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Manorcare at Oak Lawn/95th

ID# 0027540

Report Period Beginning: 06/01/03

Ending: 05/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$	21	1
2	Misc. Income	(749)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(749)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Oak Lawn/95th # 0027540 **Report Period Beginning:** 06/01/03 **Ending:** 05/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(302)	0	0	0	0	0	0	0	0	0	0	(302)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(302)	0	0	0	0	0	0	0	0	0	0	(302)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(38,499)	0	0	0	0	0	0	0	0	0	0	(38,499)	19
20	Fees, Subscriptions & Promotions	(37,107)	0	0	0	0	0	0	0	0	0	0	(37,107)	20
21	Clerical & General Office Expenses	(118,488)	0	0	0	0	0	0	0	0	0	0	(118,488)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(194,094)	0	0	0	0	0	0	0	0	0	0	(194,094)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(194,396)	0	0	0	0	0	0	0	0	0	0	(194,396)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare at Oak Lawn/95th # 0027540 **Report Period Beginning:** 06/01/03 **Ending:** 05/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(194,396)	0	0	0	0	0	0	0	0	0	0	(194,396)	45

Facility Name & ID Number Manorcare at Oak Lawn/95th # 0027540 Report Period Beginning: 06/01/03 Ending: 05/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care, Inc.	100	Health Care & Retirement Corporation of America (See H.O. Cost Report)				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	$ 815,094	HCR Manor Care, Inc.	100.00%	$ 815,094	$	1
2	V	Page								2
3	V	8								3
4	V									4
5	V									5
6	V	10a	Theapy Management	36,626	Heartland Management Services	100.00%	36,626		6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total			$ 851,720			$ 851,720	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Manorcare at Oak Lawn/95th # 0027540 Report Period Beginning: 06/01/03 Ending: 05/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Manorcare at Oak Lawn/95th # 0027540 Report Period Beginning: 06/01/03 Ending: 05/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR Manor Care, Inc.
Street Address: 333 North Summit St.
City / State / Zip Code: Toledo, OH 43604-2617
Phone Number: (419) 252-5500
Fax Number: (419) 254-5495

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,402,993,349	357 Nurs. Fac	$	$		$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,860,540,914	357 Nurs. Fac	940,169	509,589	11,028,918	3,625	2
3	5	Utilities - Direct	Accumulated Cost	2,402,993,349	357 Nurs. Fac	288,728		11,028,918	1,325	3
4	5	Utilities - Pooled	Accumulated Cost	2,860,540,914	357 Nurs. Fac	3,082,391		11,028,918	11,884	4
5	10	Nursing - Direct	Accumulated Cost	2,402,993,349	357 Nurs. Fac	11,758,547	7,451,541	11,028,918	53,968	5
6	10	Nursing - Pooled	Accumulated Cost	2,860,540,914	357 Nurs. Fac	6,213,378	3,630,889	11,028,918	23,956	6
7	17	General & Admin - Direct	Accumulated Cost	2,402,993,349	357 Nurs. Fac	17,137,345	15,146,077	11,028,918	78,655	7
8	17	General & Admin - Pooled	Accumulated Cost	2,860,540,914	357 Nurs. Fac	84,524,208	36,356,103	11,028,918	325,886	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,402,993,349	357 Nurs. Fac	4,283,731		11,028,918	19,661	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,860,540,914	357 Nurs. Fac	17,698,741		11,028,918	68,238	10
11	30	Depreciation - Direct	Accumulated Cost	2,402,993,349	357 Nurs. Fac	0		11,028,918	0	11
12	30	Depreciation - Pooled	Accumulated Cost	2,860,540,914	357 Nurs. Fac	12,354,014		11,028,918	47,631	12
13										13
14	32	Interest				11,412,188			180,265	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 169,693,440	$ 63,094,199		$ 815,094	25

Facility Name & ID Number Manorcare at Oak Lawn/95th # 0027540 Report Period Beginning: 06/01/03 Ending: 05/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Conv. Sub. Debentures		X	Facility			$ 2,340,310	$ 2,340,310		7.7026	$ 180,265	1
2	National City Bank		X	To fund fixed asset additiona		04/2003	299,483	299,483		6.2782	18,802	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8	Interest Income Other										(877)	8
9	TOTAL Facility Related						$ 2,639,793	$ 2,639,793			$ 198,190	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,639,793	$ 2,639,793			$ 198,190	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Manorcare at Oak Lawn/95th # 0027540 Report Period Beginning: 06/01/03 Ending: 05/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	366,313	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	397,230	2
3. Under or (over) accrual (line 2 minus line 1).	$	30,917	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	404,158	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	25,666	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	460,741	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	406,217	8
	2000	431,135	9
	2001	442,250	10
	2002	412,237	11
	2003	428,264	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

Line 2: $397,230 = $206,118 for 1st half of 2003 + $191,112 for 2nd half of 2002

Line 4: $404,158 = $222,146 for 2nd half of 2003 + $182,012 for Jan-May 2004

Line 5: $25,666 is the amount paid to Ernst & Young for their successful 2002 Real Estate appeal.
The Cook County Assessor and Board of Review granted a reduction in the 2002 assessment.

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare at Oak Lawn/95th COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0027540

CONTACT PERSON REGARDING THIS REPORT Gary Geise

TELEPHONE (419)252-5736 FAX #: (419)254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-05-302-005-0000	See attached	$ 428,264.12	$ 428,264.12
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 428,264.12	$ 428,264.12

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Manorcare at Oak Lawn/95th # 0027540 Report Period Beginning: 06/01/03 Ending: 05/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,284 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1981	$ 820,000	1
2					2
3	TOTALS			$ 820,000	3

Facility Name & ID Number Manorcare at Oak Lawn/95th # 0027540 Report Period Beginning: 06/01/03 Ending: 05/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	100		1981	1962	$ 313,600	$ 95,080		$ 95,080	$	$ 1,464,252	4
5	75		1981	1969	658,575						5
6	10			1987	448,818						6
7	10			1999	1,235,114						7
8											8
	Improvement Type**										
9	Current Year Depreciation					295,682		295,682		2,502,795	9
10				1985	2,374						10
11				1986	5,308						11
12				1987	5,756						12
13				1988	251,787						13
14				1989	94,354						14
15				1990	20,764						15
16				1991	63,572						16
17				1992	143,258						17
18				1993	317,964						18
19				1994	192,466						19
20				1995	469,304						20
21				1996	340,114						21
22				1997	203,364						22
23				1998	544,751						23
24				1999	207,547						24
25				2000	106,181						25
26	AIR CONDITIONING			2001	6,428						26
27	ELECTRICAL			2001	1,072						27
28	2 HOLLOW METAL DOORS			2001	3,120						28
29	ANSUL SYSTEM			2001	2,601						29
30	DOOR ALARM SERVICE			2001	2,547						30
31	VENT UNIT OFFICE REMODEL			2001	1,205						31
32	VINYL WALLCOVERING			2001	650						32
33	PAINTING			2001	2,185						33
34	WINDOW TREATMENT			2001	687						34
35	TILE - LANDURY ROOM			2001	2,925						35
36	EXTERIOR WALL REPAIR/REBUILD			2001	12,933						36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare at Oak Lawn/95th # 0027540 Report Period Beginning: 06/01/03 Ending: 05/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	EXTERIOR WALL - ELETRICAL	2001	$ 313	$		$	$	$	37
38	EXTERIOR WALL - VWC & PAINT	2001	800						38
39	VINYL WALLCOVERING	2001	6,687						39
40	HVAC & ELECTRIC	2002	37,140						40
41	WALLCOVERING, PAINT, & FLOORING	2002	60,964						41
42	WALL REPLACEMENT	2002	5,327						42
43	CARPENTRY & MILLWORK	2002	59,438						43
44	CARPET & WALLCOVERING	2002	13,156						44
45	HVAC & ELECTRICAL	2002	18,957						45
46	ELECTRICAL WORK	2002	2,768						46
47	EMERGENCY POWER UPGRADE CIRCUIT	2002	215,884						47
48	DRAINAGE WORK	2002	23,290						48
49	CARPET	2003	2,365						49
50	WALLCOVERING, BORDERS, & PAINTING	2003	8,019						50
51	WINDOW TREATMENTS	2003	3,647						51
52	TILE, CABINETS, COUNTER TOP, SINK (Soiled Utility room)	2003	36,272						52
53	HAND RAILS	2003	7,409						53
54	DOORS & FRAMES (9)	2003	17,938						54
55	TILE FLOOR & WALLS, PAINT, (Shower/Tub room)	2003	19,535						55
56	FLOOR TILE (Resident rooms)	2003	31,272						56
57	WALLCOVERING, BORDERS, & PAINTING	2003	38,430						57
58	ELECTRICAL WORK & LIGHT FIXTURES	2003	15,897						58
59	CONSTRUCTION DEPARTMENT COST & INTEREST	2003	25,344						59
60	PARKLING LOT UPGRADE	2003	32,065						60
61	FENCING AROUND DUMPSTER	2003	7,898						61
62	DOORS	2004	7,344						62
63	CARPET	2004	10,711						63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,370,194	$ 390,762		$ 390,762	$	$ 3,967,047	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Oak Lawn/95th # 0027540 Report Period Beginning: 06/01/03 Ending: 05/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,894,348	$ 146,026	$ 146,026	$		$ 1,479,449	71
72	Current Year Purchases	241,459						72
73	Fully Depreciated Assets							73
74				47,631	47,631			74
75	TOTALS	$ 2,135,807	$ 146,026	$ 193,657	$ 47,631		$ 1,479,449	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident	1995 Goshen GCH	1995	$ 12,107	$	$	$		$ 12,107	76
77		Paratransit								77
78										78
79										79
80	TOTALS			$ 12,107	$	$	$		$ 12,107	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,338,108	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 536,788	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 584,419	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 47,631	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,458,603	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 44,509 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elct. Beds, Etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Manorcare at Oak Lawn/95th # 0027540 Report Period Beginning: 06/01/03 Ending: 05/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	6414 hrs	$ 193,773	332	$ 19,118	$ 2,361	6,746	$ 215,252	1
2	Licensed Speech and Language Development Therapist	10a	3212 hrs	123,734	1,210	69,681	761	4,422	194,176	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	4334 hrs	130,535	341	19,623	4,340	4,675	154,498	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescrpts				615,245		615,245	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab & X-ray	43, 3				183,198			183,198	13
14	TOTAL			$ 448,042	1,882	$ 291,620	$ 622,707	15,842	$ 1,362,369	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Manorcare at Oak Lawn/95th # 0027540 **Report Period Beginning:** 06/01/03 **Ending:** 05/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 05/31/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 18,000	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 369,703)	2,089,993		3
4	Supply Inventory (priced at)	15,797		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,468		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,131,258	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	820,000		13
14	Buildings, at Historical Cost	6,371,327		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,146,781		16
17	Accumulated Depreciation (book methods)	(5,458,603)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction in Progress	93,625		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,973,130	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,104,388	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 169,662	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	470,178		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	404,158		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	157,542		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,201,540	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	299,483		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	41,233		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 340,716	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,542,256	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,562,132	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,104,388	$	48

***(See instructions.)**

Facility Name & ID Number Manorcare at Oak Lawn/95th # 0027540 Report Period Beginning: 06/01/03 Ending: 05/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,751,672	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,751,672	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,546,170	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 2,546,170	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(2,735,710)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (2,735,710)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,562,132	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,147,773	1
2	Discounts and Allowances for all Levels	(3,212,466)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,935,307	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,632,620	6
7	Oxygen	111,239	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,743,859	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	986	12
13	Barber and Beauty Care	11,368	13
14	Non-Patient Meals	302	14
15	Telephone, Television and Radio	5,679	15
16	Rental of Facility Space		16
17	Sale of Drugs	613,410	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	118,604	19
20	Radiology and X-Ray	85,103	20
21	Other Medical Services		21
22	Laundry	2,119	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 837,571	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income & Purchase Discount	744	28
28a	Late Charges	(998)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (254)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,516,483	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,335,621	31
32	Health Care	5,347,620	32
33	General Administration	3,013,152	33
	B. Capital Expense		
34	Ownership	1,061,610	34
	C. Ancillary Expense		
35	Special Cost Centers	1,105,254	35
36	Provider Participation Fee	107,056	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,970,313	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,546,170	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,546,170	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	983	1,062	$ 34,713	$ 32.69	1
2	Assistant Director of Nursing	4,557	4,923	152,280	30.93	2
3	Registered Nurses	34,085	36,825	949,650	25.79	3
4	Licensed Practical Nurses	62,834	67,886	1,214,798	17.89	4
5	Nurse Aides & Orderlies	132,943	143,632	1,315,389	9.16	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	15,286	16,656	488,194	29.31	7
8	Rehab/Therapy Aides	16,332	17,796	315,439	17.73	8
9	Activity Director	11,039	11,960	128,128	10.71	9
10	Activity Assistants					10
11	Social Service Workers	5,865	6,374	93,461	14.66	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	32,339	34,880	364,943	10.46	15
16	Dishwashers					16
17	Maintenance Workers	4,074	4,411	75,119	17.03	17
18	Housekeepers	21,201	22,991	199,708	8.69	18
19	Laundry	6,661	7,218	52,305	7.25	19
20	Administrator	2,080	2,080	102,435	49.25	20
21	Assistant Administrator	482	482	16,232	33.68	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	23,452	25,527	452,266	17.72	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	6,956	7,530	91,921	12.21	31
32	Other Health Care(specify)					32
33	Other(specify) Hospitalty					33
34	TOTAL (lines 1 - 33)	381,169	412,233	$ 6,046,981 *	$ 14.67	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	28,500	9, 3	36
37	Medical Records Consultant		6,830	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,020	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 42,350		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	6	332	10, 3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	6	$ 332		53

Facility Name & ID Number Manorcare at Oak Lawn/95th # 0027540 Report Period Beginning: 06/01/03 Ending: 05/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Denise Clements	Administrator	0	$ 102,435
Karen Petyko	Asst. Administrator	0	16,232
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 118,667

B. Administrative - Other

Description	Amount
Management Fees	$ 815,094
TOTAL (agree to Schedule V, line 17, col. 3)	$ 815,094
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Foote, Meyers, Mielke, Flowers & So	Legal Fees	$ 32,216
McVey & Parsky	Legal Fees	5,558
Sandra Lynn Theil	Legal Fees	625
Rogers Tower	Legal Fees	100
Physicians Credit Bureau	Collections of AR Balances	1,339
Carol Walters	Wound Care	11,869
Aesthetic & Clinical Dermatology Association		1,000
Salt Creek Therapy	Therapy	150
Allan C Katz MD	Dentist	150
Legal fees were adjusted off on Schedule VI, Page 5, Line 22.		
Therefore, no legal invoices are attached.		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 53,007

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 76,359
Unemployment Compensation Insurance	71,418
FICA Taxes	431,381
Employee Health Insurance	358,014
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreiation	8,669
401K	35,401
Other Employee Benefits	(1,142)
Tuition Program	1,073
SMSP Match	8,650
Employee Uniforms	2,492
Home Office Allocation	87,899
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,080,214

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 5,095
Advertising: Employee Recruitment	26,418
Health Care Worker Background Check	
(Indicate # of checks performed 282)	5,407
Dues & Subscriptions	80
Association Dues	9,112
Advertising	30,983
Public Relations	3,313
Less Non-allowable Association Dues	(2,811)
Less: Public Relations Expense	(3,313)
Non-allowable advertising	(30,983)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 43,301

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	5,495
Includes travel expense to the Home	
Office in Toledo, OH for regional meetings	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,495

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Manorcare at Oak Lawn/95th # 0027540 Report Period Beginning: 06/01/03 Ending: 05/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Manorcare at Oak Lawn/95th # 0027540 **Report Period Beginning:** 06/01/03 **Ending:** 05/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $9112**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes $2811**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **82,971** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **107,056**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **302**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **No**
Attach invoices and a summary of services for all architect and appraisal fees.